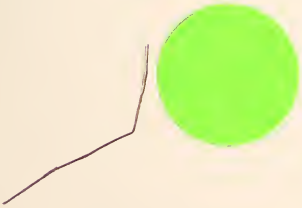
Medicare Coverage of Kidney Dialysis and Kidney Transplant Services

A supplement to Your Medicare Handbook



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MEDICARE AND TREATMENT FOR PERMANENT KIDNEY FAILURE

This supplement to *Your Medicare Handbook* explains the special rules that apply to Medicare coverage and payment for kidney dialysis and transplant services.

Medicare also helps pay for a wide range of other health services and supplies. *Your Medicare Handbook* describes the other health services and supplies that are covered by Medicare and how payments are made. If you don't have a copy of the Handbook, you can get one at any Social Security office.

THE TWO PARTS OF MEDICARE

Medicare has two parts—hospital insurance and medical insurance. This section briefly describes each part. For more detailed information, see *Your Medicare Handbook*.

HOSPITAL INSURANCE

Hospital insurance covers medically necessary inpatient hospital care. Under certain conditions, it also covers medically necessary inpatient care in a skilled nursing facility after a hospital stay, home health care, and hospice care. The hospital insurance part of Medicare, for example, helps pay for an inpatient stay in an approved hospital for kidney transplant surgery.

Hospital insurance has a deductible which must be met each time your admission to a hospital starts a new benefit period. In 1987, the hospital insurance deductible is $520.

Medicare payments for services covered by hospital insurance are made directly to the participating hospital, skilled nursing facility, home health agency, and hospice.

MEDICAL INSURANCE

Medical insurance covers doctor's services, outpatient hospital services, outpatient physical therapy and speech pathology services, and many other health services and supplies.

Most of the services and supplies needed by people with permanent kidney failure are covered only by medical insurance. For example, medical insurance covers outpatient maintenance dialysis, self-dialysis training, and home dialysis.

If you became entitled to Medicare before you developed permanent kidney failure and have not signed up for medical insurance or if your medical insurance has stopped, you can apply for this protection now. The amount of your monthly premium will be the current basic rate—$17.90 through December 31, 1987. If you already have medical insurance but are paying a higher premium, the amount can be reduced to the current basic rate. Get in touch with any Social Security office for more information.

There is a deductible which must be met each year before payments can be made for services and supplies covered by medical insurance. In 1987, the medical insurance deductible is $75. The deductible can be made up of charges for any covered services and supplies. There is not a separate deductible for each covered service. After the annual deductible is met, medical insurance generally pays 80 percent of the approved charges for covered services you receive during the rest of the year.

WHEN MEDICARE PROTECTION BEGINS

When you become entitled to Medicare because of permanent kidney failure, your Medicare protection starts with the 3rd month after the month your course of maintenance dialysis treatments begin. For example, if you began receiving maintenance dialysis treatments in July, your Medicare coverage would start on October 1.

There are two ways your Medicare protection can begin earlier.

- Medicare coverage can begin in the *1st month* of dialysis if you participate in a self-dialysis training program in a Medicare-approved training facility before the 3rd month after dialysis begins, *and* you are expected to complete the training and self-dialyze thereafter.
- Medicare coverage can begin the month you are admitted to an approved hospital for a kidney transplant or procedures preliminary to a transplant *if* the transplant takes place in that month or within the 2 following months. But, if the transplant is delayed more than 2 months after you are admitted to the hospital, Medicare coverage will begin the 2nd month before the month the actual transplant takes place or, if earlier, the 1st day of the 3rd month after maintenance dialysis began.

WHEN MEDICARE PROTECTION ENDS

For people entitled to Medicare *only* because of permanent kidney failure, Medicare protection ends 12 months after the month they no longer require maintenance dialysis treatments or 36 months after the month of a kidney transplant. But, if the transplant fails during or after that 36-month period and the person again resumes maintenance dialysis or receives another transplant, Medicare coverage will continue or be reinstated immediately without any waiting period.

Your Medicare medical insurance can stop at any time if you fail to pay premiums or if you decide to cancel it.

MEDICARE PAYMENT FOR BENEFICIARIES COVERED BY EMPLOYER GROUP HEALTH PLANS

If you become entitled to Medicare *only* because of permanent kidney failure and are covered by an employer group health plan, Medicare will be the secondary payer during an initial period of up to 12 months. In general, the period in which Medicare may be secondary begins with the month regular dialysis starts, or if you become entitled to Medicare because of a kidney transplant, when Medicare protection begins. Employer plans pay first for kidney treatment and other health services furnished during the period in which Medicare is secondary. However, if the employer plan doesn't pay in full, Medicare may make secondary payments to supplement the amount paid by the employer plan. At the end of the 12-month period, Medicare becomes the primary payer. If you are covered by an employer group health plan during the 12-month period, you should tell the person who furnishes you with medical services so that the services can be billed correctly.

WHO CAN PROVIDE MAINTENANCE DIALYSIS AND TRANSPLANT SURGERY

To receive Medicare payments, medical facilities must be specifically approved to provide maintenance dialysis or kidney transplant surgery—even if they already participate in Medicare to provide other health care services covered by the program.

They must meet special health, safety, professional, staffing, and minimum utilization standards directly related to dialysis and kidney transplant services. And, they must meet Federal, State, and local requirements for medical facility planning.

Your doctor or the facility can tell you whether a facility is approved by Medicare for payment of dialysis and transplant services.

COVERAGE OF MAINTENANCE DIALYSIS

This section explains coverage and payment for outpatient maintenance dialysis and the conditions under which inpatient dialysis is covered.

OUTPATIENT DIALYSIS

Medicare medical insurance helps pay for outpatient maintenance dialysis treatments in any approved dialysis facility. This includes the costs of laboratory tests, equipment, supplies, and other services associated with your treatment. Medical insurance payments for outpatient maintenance dialysis furnished in the facility are always made to the facility.

Charges for maintenance dialysis will vary from one approved facility to another. The facilities' charges are based on their costs of providing dialysis treatments. The cost of treatment will depend on various factors such as the costs of professional services and equipment in the area, the size of the facility, and other justifiable operating costs that can differ between one approved facility and another. Medicare pays the facility based on a per treatment rate that is set in advance. This rate is the facility's *composite rate*. The facility may charge you only 20 percent of this rate. For example, a typical rate might be $130 per treatment. In that case, if the $75 deductible has already been met, medical insurance would pay 80 percent of $130 (or $104). Medicare *cannot* pay the remaining 20 percent of the charge (or $26). You are responsible for 20 percent coinsurance.

Occasionally, maintenance peritoneal dialysis treatments will extend overnight. These extended peritoneal treatments are covered as outpatient services by medical insurance. Consequently, any overnight stays will not reduce the number of inpatient days covered by your Medicare hospital insurance unless you require inpatient care for additional specialized services.

Many of the laboratory tests you receive may be included as part of the facility's maintenance dialysis services. But, if you need additional tests, they can be covered as independent laboratory services, outpatient hospital services, or as part of your doctor's services. For more information, see the chapters on doctors' services, outpatient hospital services, and other services and supplies in *Your Medicare Handbook*.

INPATIENT DIALYSIS

Generally, maintenance dialysis treatments are covered on an outpatient basis. But if you are admitted to a hospital because your medical condition requires the availability of other specialized hospital services on an inpatient basis, your maintenance dialysis treatments would be covered by hospital insurance as part of the costs of your covered inpatient hospital stay.

Please read *Your Medicare Handbook* for a detailed explanation of the coverage of inpatient hospital care. You should note that when you are admitted into a hospital as an inpatient, you use hospital days from your Medicare benefit period. Benefit periods are explained in *Your Medicare Handbook*. To be hospitalized for dialysis may be costly in the long run because you may need your hospital days for some future illness.

DOCTORS' SERVICES AND MAINTENANCE DIALYSIS

Doctors' services are covered by Medicare medical insurance. While you are on maintenance dialysis, medical insurance can pay for your doctor's services in the following ways.

- **OUTPATIENT MAINTENANCE DIALYSIS**

  Medicare pays benefits for all services related to outpatient maintenance dialysis. The Medicare carrier pays for those services through a monthly capitation payment (MCP). The same monthly amount is paid for each patient the doctor supervises, regardless of whether the patient dialyzes at home or as an outpatient in an end-stage renal disease (ESRD) facility. Using this method of physician payment, medical insurance pays 80 percent of the monthly fee, minus any part of the $75 deductible you have not met. If your doctor accepts assignment, Medicare payment is made directly to him/her; otherwise, you receive the payment.

  Services from your doctor which are not related to or not provided at the time of treatment of your kidney condition are not included in the monthly payment. For example, during a visit to your doctor for your kidney condition, you might receive services for bronchitis. All of the services you receive during this visit would be included in the monthly payment. But, any additional visits for followup care of the bronchitis would not be included in the monthly payment. Medical insurance can help pay for additional services of this kind as explained in *Your Medicare Handbook.*

  The monthly payment covers only physician services. Medicare pays an extra amount for any medical supplies your doctor may furnish.

- **INPATIENT MAINTENANCE DIALYSIS**

  If you are hospitalized, your doctor has a choice of two methods of payment for furnishing services to you as an inpatient. Your doctor may choose to continue to receive the monthly payment, in which case you cannot be billed for any additional amounts. Or, your doctor can choose to bill separately for the inpatient services, which Medicare will pay for in the manner described in *Your Medicare Handbook.* In this case, your doctor's monthly payment will be reduced based on the number of days you are hospitalized.

SELF-DIALYSIS TRAINING

Self-dialysis training is covered by Medicare medical insurance on an outpatient basis.

Coverage of self-dialysis training includes your instruction and instruction for the person who will assist you with maintenance self-dialysis at home. Medical insurance also covers the maintenance dialysis treatment and laboratory tests and other services and supplies associated with the treatment.

Medicare *cannot* cover the cost of paid dialysis aides to assist self-dialysis patients at home. Medicare also *cannot* cover the costs of transportation to and from the outpatient dialysis center, wages that you and your assistant lose while being trained, or the cost of lodging during treatment.

Payment rates for self-dialysis training sessions are higher than those for maintenance dialysis treatments. While charges will vary from one dialysis facility to another, depending upon type of facility and its geographic location, a typical charge might be $150 per session. If the annual deductible has already been met, medical insurance would pay 80 percent of the training rate (or $120). Medicare *cannot* pay the remaining 20 percent (or $30).

For the services of the doctor who is conducting your self-dialysis training, the maximum total charge medical insurance will approve is $500. If your doctor charges $500, medical insurance would pay 80 percent of $500 (or $400) if the deductible has already been met. Medicare *cannot* pay the remaining 20 percent (or $100).

Retraining for self-dialysis—for example, in the use of new equipment—is also covered by Medicare medical insurance on an outpatient basis.

HOME DIALYSIS

Medicare medical insurance covers home dialysis equipment, all necessary supplies, and a wide range of home support services. Home dialysis includes home hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD).

Usually, drugs used in your home are not covered unless a doctor administers them. However, certain drugs for home dialysis patients are covered even though a doctor is not present. The most common of these are heparin, the antidote for heparin when medically indicated, and topical anesthetics. Blood or packed red blood cells *cannot* be covered for home dialysis unless your doctor administers it or personally directs its administration, or if the blood is needed to prime your dialysis equipment (see "Blood Coverage" in *Your Medicare Handbook).*

PAYMENT OPTIONS UNDER HOME DIALYSIS

If you dialyze at home, you can choose between two payment options: *Method 1* or *Method II.* These options are described below. To make a choice, you complete the Beneficiary Selection Form HCFA-382, sign it and return it to the facility supervising your care. Once you make your initial choice, you must continue under that option until December 31 of that year. You can change from one *Method* to the other by filing a new Form 382 at any time, but the change does not go into effect until the following January 1. It is important to remember that choosing *Method I* or *Method II* does not in any way prevent you from returning to treatment in a center, selecting another kind of treatment for ESRD care, or choosing to associate with another facility.

Method I: The Composite Rate

If you choose *Method I* your dialysis facility is responsible for providing all services, equipment and supplies necessary for home dialysis. Medicare pays the facility directly for these items and services at a pre-determined composite rate. Under this arrangement, you are responsible for paying the $75 deductible and the 20 percent coinsurance on the Medicare rate to the facility.

Method II: Dealing Directly With Medicare

If you choose *Method II,* you receive payment directly from Medicare for covered home dialysis equipment and supplies. Under this arrangement, you must obtain these items directly from the supplier and are responsible for paying the supplier yourself. However, if you choose to obtain the home dialysis equipment and supplies from your facility, Medicare pays the facility directly. Whether you obtain the items from a supplier or from your facility, you are responsible for any unmet part of the $75 deductible and for 20 percent coinsurance of the approved charges for these items.

Under both *Methods,* you must receive your home dialysis support services from your facility, for which Medicare pays the facility directly.

HOME DIALYSIS EQUIPMENT

Under *Method I,* all home dialysis equipment and equipment-related services are covered under the facility's composite rate payment. Under *Method II,* medical insurance also covers rental or purchase of dialysis equipment for home use. Delivery and installation charges are included as part of the approved charge.

Whether you rent or buy dialysis equipment, medical insurance usually makes monthly payments. If you buy dialysis equipment, the monthly medical insurance payment includes any reasonable interest or carrying charges that may be part of an installment purchase agreement with the supplier of the equipment.

After the $75 deductible, medical insurance pays 80 percent of the approved monthly rental charge or the approved monthly installment purchase price for your home dialysis equipment.

Medical insurance payments for you home dialysis equipment can continue as long as you need to be dialyzed at home. If your need for home dialysis stops, medical insurance payments also stop. For example, if you no longer need to be dialyzed because you have successful kidney transplant surgery, then medical insurance payments for your home dialysis equipment would usually stop.

If you stop using your home dialysis equipment temporarily—for example, because you are traveling or are hospitalized—medical insurance will continue its payments for the equipment for up to 3 months after the month in which you last used the equipment. If at a later date you use the equipment again, medical insurance payments would also start again.

Of course, if you purchase your dialysis equipment, medical insurance payments always stops when the purchase price approved as a basis for payments is reached.

NOTE: Before August 1, 1983, a special rule applied if you obtained your home dialysis equipment from an approved hospital, facility, or nonprofit third party organization which reserved the equipment for the exclusive use of Medicare patients on home dialysis. If you obtained your equipment under this arrangement, Medicare paid the hospital or facility for the full reasonable cost of the equipment, including installation and maintenance, for as long as you needed it.

Any equipment obtained before August 1, 1983, will still be handled under this special rule. If you have equipment under this rule and choose *Method I,* your facility's composite rate is reduced by $12 per treatment. Therefore, your coinsurance liability is reduced by 20 percent of $12, or $2.40. This reduction is made as long as the dialysis machine purchased under this special rule is still in use in your home.

After August 1, 1983, no home dialysis equipment can be purchased under this special rule, but equipment that was purchased and in use before August 1, 1983 can be used by subsequent patients for as long as the equipment lasts.

HOME DIALYSIS SUPPLIES

Medical insurance covers all supplies necessary to perform home dialysis. This includes disposable items such as alcohol wipes, sterile drapes and rubber gloves, foreceps, scissors, and topical anesthetics. Under *Method I,* all home dialysis supplies are covered under the facility's composite rate payment. Under *Method II,* after the $75 deductible, medical insurance pays 80 percent of the approved charges for all covered items. Whenever possible, you should accumulate bills until they reach $10 or more before sending in your claim for payment.

HOME DIALYSIS SUPPORT SERVICES

Medical insurance covers periodic support services, furnished by an approved hospital or facility, which are necessary to help you remain on home dialysis. After your doctor approves the plan of treatment, such support services may include visits by trained hospital or facility personnel to periodically monitor your home dialysis and to assist in emergencies when necessary. Medical insurance also covers the services of qualified facility or hospital personnel to help with the installation and maintenance of your dialysis equipment and to test and appropriately treat your water supply system.

Under *Method I,* all home dialysis support services are covered under the facility's composite rate payment. Under *Method II,* medical insurance pays directly to the facility 80 percent of the approved charges for all covered services after the $75 deductible has been met.

KIDNEY TRANSPLANT SURGERY

Both parts of Medicare help pay for kidney transplant surgery.

WHAT HOSPITAL INSURANCE PAYS FOR

Medicare hospital insurance covers your inpatient hospital services in an approved hospital when you are admitted for kidney transplant surgery. Hospital insurance also covers hospital services in preparation for your kidney transplant. This includes the Kidney Registry fee and services such as laboratory and other tests that are required to evaluate your medical condition and the medical conditions of potential kidney donors. These preparatory services are covered whether they are done by the approved hospital where your transplant surgery will take place or by another hospital that participates in Medicare. If there is no kidney donor, the costs of obtaining a suitable kidney for your transplant surgery are also covered.

When your admission to a hospital for transplant surgery starts a benefit period, hospital insurance pays for all covered inpatient hospital services for the 1st through the 60th day, *except the $520 hospital insurance deductible.* For the 61st through the 90th day, hospital insurance pays for all covered services, *except for $130 a day.*

In addition to 90 inpatient hospital days in each benefit period, you have a lifetime total of 60 inpatient hospital reserve days. Reserve days, however, are *not* renewable. Hospital insurance pays for all covered services *except for $260 a day* for each reserve day you use. (For more information about inpatient hospital care, see "When you are a hospital inpatient" in *Your Medicare Handbook.)*

Hospital insurance pays the full cost of care for a person who donates a kidney for your transplant surgery. This includes all reasonable preparatory, operation, and post-operative recovery expenses connected with the donation. There is no deductible or daily amount for your donor's hospital stay, and the number of days your donor uses does not reduce the number of inpatient days that you may use in a benefit period. The inpatient hospital stay does not qualify your donor for any Medicare benefits not associated with the kidney donation. But, Medicare hospital insurance will pay for any additional inpatient hospital care your donor might need if complications result directly from the kidney donation. No payment is made for the kidney itself. If a donor sells his/her kidney, the purchase price is not covered by Medicare. Futhermore, the purchase of human organs is prohibited by law.

Medicare hospital insurance payments are made directly to the hospital.

WHAT MEDICAL INSURANCE PAYS FOR

Medicare medical insurance covers your surgeon's services for performing the kidney transplant operation. This includes pre-operative care, the surgical procedure, and followup care. Medical insurance also covers doctors' services provided to your kidney donor during his or her inpatient hospital stay while you are receiving a kidney transplant.

After the $75 medical insurance deductible is met, medical insurance pays 80 percent of the approved charge for your surgeon's services to you. There is no deductible or coinsurance for doctors' services provided to your kidney donor; Medicare pays these services in full. Medical insurance payments for your surgeon's services are paid for as explained in *Your Medicare handbook* (see "How payments are made").

Effective January 1, 1987, Medicare pays for your immunosuppressive drugs for a period of one year following your discharge from the transplant hospital. This benefit is subject to the Part B deductible and coinsurance provisions.

HOW MEDICARE PAYS FOR BLOOD

Both parts of Medicare can help pay for whole blood or units of packed red blood cells, blood components, and the cost of blood processing and administration.

If you receive blood as an inpatient of a hospital or skilled nursing facility, hospital insurance can pay all of these blood costs, *except for any nonreplacement fees charged for the first 3 pints of whole blood or units of packed red cells in each benefit period.* The nonreplacement fee is the charge that some hospitals and skilled nursing facilities make for blood which is not replaced.

You are responsible for the nonreplacement fees for the first 3 pints or units of blood furnished by a hospital or skilled nursing facility. If you are charged nonreplacement fees, you have the option of either paying the fees or having the blood replaced. If you choose to have the blood replaced, you can arrange for another person or a blood assurance plan to replace it for you. A hospital or skilled nursing facility cannot charge you for any of the first 3 pints of blood you have replaced or have arranged to replace.

Medical insurance can help pay for blood and blood components you receive as an outpatient or as part of other covered services, *except for any nonreplacement fees charged for the first 3 pints or units received in each calendar year.* After you have met the $75 deductible, medical insurance pays 80 percent of the approved charges for blood starting with the fourth pint in a calendar year.

Medicare does not cover blood in connection with self-dialysis at home unless it is provided as part of a doctor's service or is needed solely for the purpose of priming the dialysis equipment.

WHAT MEDICARE DOES NOT COVER

The following list shows some of the services and supplies that Medicare does not cover in connection with diaysis and transplant services. *Your Medicare Handbook* lists other services and supplies which are not covered by Medicare (see "What Medicare does not cover").

Ambulance or other transportation costs to a facility for routine outpatient maintenance dialysis

Dialysis aides' services to assist in home dialysis

Drugs and medicines you buy yourself with or without a prescription except heparin, the antidote for heparin, and topical anesthetics

Inpatient hospital and skilled nursing facility costs when the stay is solely for maintenance dialysis

Lodging costs when an outpatient dialysis facility is not near your home

Wage losses to you and your dialysis partner during self-dialysis training

OTHER PAYMENT SOURCES

If you have health care protection from private health insurance, the Veterans Administration, the Indian Health Service, a Federal employee's health plan, CHAMPUS, or another source, it also may help pay for services you need for the treatment of permanent kidney failure.

In most States there are agencies that help with some of the medical expenses Medicare does not cover. Some States have Kidney Commissions that assist people in meeting the expenses Medicare cannot pay. And most States have a Medicaid program that helps pay medical expenses in cases of serious finacial need.

Under certain circumstances, employer group health plans, including Federal employee health plans, will be required to pay their benefits before Medicare pays (see page 4).

DIALYSIS PATIENTS WHO TRAVEL

If you are a dialysis patient and plan to travel, you should make arrangements for dialysis care along the route of your trip before you travel away from your usual dialysis facility. You are responsible for ensuring that an approved dialysis facility along the way has space and time available for your care, and that the physician and other medical personnel at the facility have enough information about you to treat you properly. Your facility will assist you in furnishing the necessary medical information.

When you plan your trip, take into account the location of Medicare approved dialysis facilities. There are over 1,400 facilities around the country. Your facility, dialysis network, or local kidney organization should be able to help you obtain the names and addresses of those facilities.

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